TEXAS SPINE & INJURY CENTER

PATIENT INFORMATION FORM

General Information

Date:	Name: _____ First Last MI			SS #: _____-_____-_____
Home phone:	Cell phone:	Sex: ❑ Male ❑ Female	Age: _____	Birth date: ____/____/____ MM DD YY
Address:		City/State:		Zip:
Email:		❑ Married ❑ Separated ❑ Divorced ❑ Single ❑ Widowed ❑ Partnered ❑ Minor		
Occupation:		Patient employer/school:		Employer/School phone:
Spouse or Parent Name: _____ First _____ Last _____ MI			Birth Date: ____/____/____ MM DD YY	SS #: _____/_____/_____
Spouse or Parent Employer:		How did you hear about us?		

Emergency Information

In case of emergency, contact: _____ First _____ Last		Relationship:
Home phone:	Work phone:	Cell phone:
Primary care physician name:		Primary care physician phone number:

Accident Information

Is condition due to an accident? ❑ yes ❑ no	Date of accident:	Type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other	To whom have you made a report of your accident? ❑ Auto insurance ❑ Employer ❑ Worker's Comp ❑ Other
Attorney name (if applicable):			Attorney phone (if applicable):

Name: _____ **Date:** _____

Insurance

Who is responsible for this account?	Relationship to patient:	SS #: _____ - _____ - _____
Primary insurance company name:	Subscriber Name:	
DOB:	ID #:	Group #:
Is patient covered by additional insurance? ❑ yes ❑ no	Secondary insurance company name:	Subscriber Name:
DOB:	ID #:	Group #:

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and deterring insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of patient, parent, guardian or personal representative | Print name of patient, parent, guardian, or personal representative

_____ _____

Date | Relationship to patient

Patient Condition

Reason for your visit?		When did your symptoms begin?
Is this condition getting progressively worse? ❑ yes ❑ no ❑ unknown	Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): 1 2 3 4 5 6 7 8 9 10	
Type of pain: ❑ sharp ❑ dull ❑ throbbing ❑ numbness ❑ aching ❑ burning ❑ shooting ❑ cramping ❑ tingling ❑ swelling ❑ stiffness ❑ other		How often do you have this pain?
Is it constant or does it come and go?	Does it interfere with your (check all that apply): ❑ sleep ❑ work ❑ recreation ❑ daily routine	Activities that are painful to perform (check all that apply): ❑ sitting ❑ standing ❑ bending ❑ walking ❑ lying down

Treatment you are receiving or have received for this condition:

❑ Medical Care _____ ❑ Chiropractic Care _____

❑ Physical Therapy _____ ❑ Other _____

Name: _____ **Date:** _____

Review of Systems

Constitutional	No	Yes	Respiratory	No	Yes	Eye	No	Yes
Excessive thirst	❑	❑	Chest pain	❑	❑	Eye pain	❑	❑
Chills	❑	❑	Chronic cough	❑	❑	Failing vision	❑	❑
Convulsions	❑	❑	Difficulty breathing	❑	❑	Far sighted	❑	❑
Dizziness	❑	❑	Spitting up blood	❑	❑	Near sighted	❑	❑
Fainting	❑	❑	Spitting up phlegm	❑	❑	Glaucoma	❑	❑
Fatigue	❑	❑	Wheezing	❑	❑	Blurred vision	❑	❑
Fever	❑	❑	Asthma	❑	❑	**Ears, Nose, and Throat**		
Weight loss	❑	❑	**Gastrointestinal**			Ringing in ears	❑	❑
Loss of sleep	❑	❑	Excessive belching	❑	❑	Colds	❑	❑
Night sweats	❑	❑	Excessive gas	❑	❑	Deafness	❑	❑
Psychiatric			Colitis	❑	❑	Earaches	❑	❑
Nervousness	❑	❑	Colon trouble	❑	❑	Ear discharge	❑	❑
Depression	❑	❑	Constipation	❑	❑	Ear noise	❑	❑
Mood swings	❑	❑	Diarrhea	❑	❑	Enlarged glands	❑	❑
Musculoskeletal			Difficult digestion	❑	❑	Enlarged thyroid	❑	❑
Arthritis	❑	❑	Bloated abdomen	❑	❑	Gum trouble	❑	❑
Bursitis	❑	❑	Excessive hunger	❑	❑	Hay fever	❑	❑
Foot trouble	❑	❑	Gallbladder trouble	❑	❑	Hoarseness	❑	❑
Hernia	❑	❑	Hemorrhoids	❑	❑	Nasal obstruction	❑	❑
Neck pain	❑	❑	Intestinal worms	❑	❑	Nose bleeds	❑	❑
Mid back pain	❑	❑	Jaundice	❑	❑	Sinus infections	❑	❑
Low back pain	❑	❑	Liver trouble	❑	❑	Sore throat	❑	❑
Fractures	❑	❑	Nausea	❑	❑	**Genitourinary**		
Cardiovascular			Stomach pain	❑	❑	Blood in urine	❑	❑
Hardening of arteries	❑	❑	Poor appetite	❑	❑	Frequent urination	❑	❑
High blood pressure	❑	❑	Vomiting	❑	❑	Kidney infection	❑	❑
Low blood pressure	❑	❑	Vomiting of blood	❑	❑	Painful urination	❑	❑
Chest pain	❑	❑	**Skin**			Prostate trouble	❑	❑
Poor circulation	❑	❑	Bruise easily	❑	❑	Seizures	❑	❑
Rapid heartbeat	❑	❑	Dryness	❑	❑	Are you pregnant?	❑	❑
Slow heartbeat	❑	❑	Hives/allergy	❑	❑	**Neurological**		
Swelling of ankles	❑	❑	Itching	❑	❑	Tremors	❑	❑
			Varicose veins	❑	❑	Fainting spells	❑	❑
						Coordination difficulty	❑	❑

Habits

	Yes	No	If yes, please describe:
Smoking	❑	❑	Packs per day: ❑ 0-½ ❑ ½-1 ❑ 2 or more How long? _____
Alcohol consumption	❑	❑	Number of drinks per day _____ # of drinks per week _____
Other drug use (street drugs)	❑	❑	
Exercise	❑	❑	❑ Daily ❑ Weekly ❑ Monthly Type _____

Medications

Please list all currently used medications and dosage. Include prescription and non-prescription drugs.

_____

_____

Name: _____ **Date:** _____

Allergies

Please list all known allergies, especially to medications.

_____

Surgeries

YEAR	BODY REGION	PROCEDURE

Family History

Please mark relative's current age or age at time of death. Place an X in the boxes that apply to them. Describe "Other" and list cause of death.

	Age	Allergy-Asthma	Alcohol abuse	Arthritis - Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Other (describe)	
Father																			
Mother																			
Brothers & Sisters																			

Prior Auto Accidents/Work Injuries

YEAR	AUTO/WORK COMP	BODY REGION(S)	LENGTH OF TREATMENT

Medical Illnesses

List current and past illnesses not mentioned above.

_____

_____

Patient/Responsible Party Signature: x_____ Date: _____

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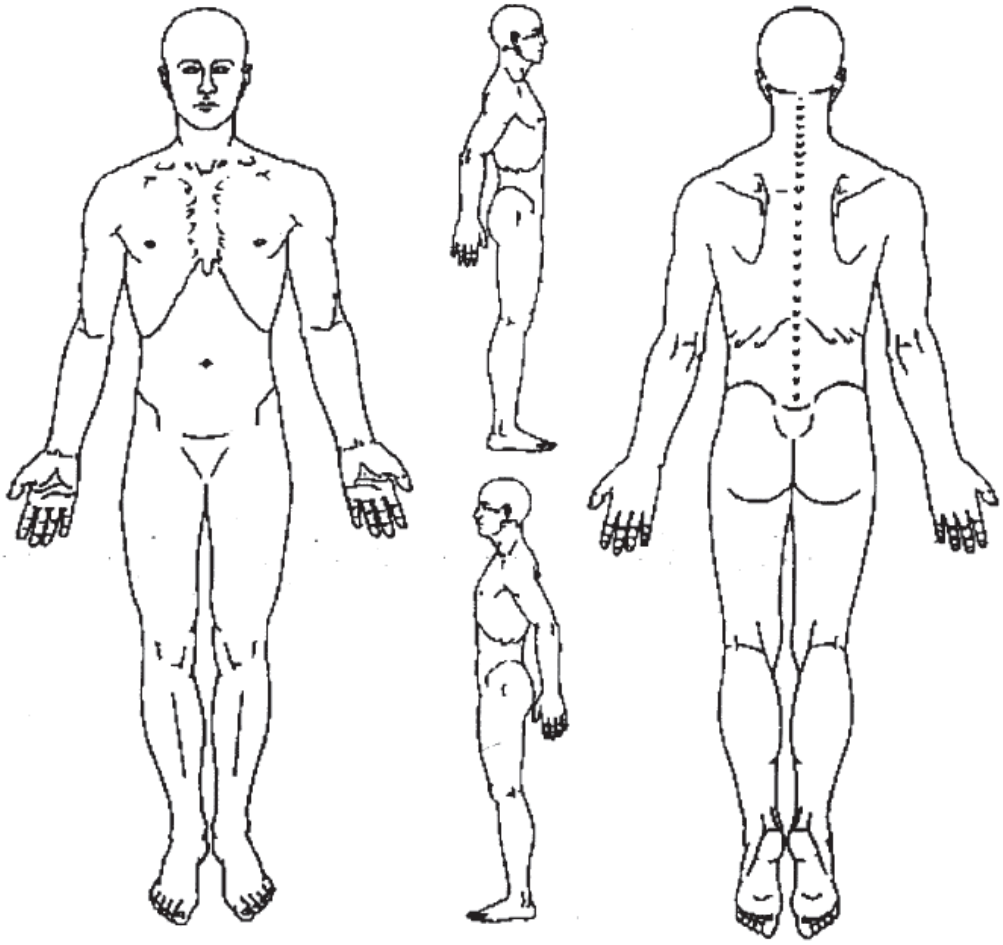

On the above diagram, please indicate where you are experiencing pain and/or other symptoms.

A = Ache	S = Stabbing
P = Pins & Needles	N = Numbness
B = Burning	O = Other

Patient Name: _____ Date: _____

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Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient,
and "The Doctor" refers Aaron Smith DC, and/or staff.

I consent to the use or disclosure of my protected health information by The Doctor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of The Doctor. I understand that analysis, diagnosis or treatment of me by The Doctor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Doctor is not required to agree to the restrictions that I may request. However, if The Doctor agrees to a restriction that I request, the restriction is binding on The Doctor. I have the right to revoke this consent, in writing, at any time, except to the extent that The Doctor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of The Doctors and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of The Doctor. The Notice of Privacy Practices for The Doctor is also posted in the waiting room at 1603 Medical Parkway Suite 310 Cedar Park, TX 78613. This Notice of Privacy Practices also describes my rights and duties of the The Doctor with respect to my protected health information.

The Doctor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of The Doctor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority

1603 Medical Parkway, Suite 310, Cedar Park, TX 78613
Phone: (512) 918-2225 Fax: (512) 918-2229

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, chiropractic assistants and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment(s) (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment, based upon facts known, that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to, fractures, disc injuries, strokes, and strains/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for my future conditions for which I seek treatment.

_____ _____
Patient's Name (Print) Patient's Signature

_____ _____
Date Relationship or authority if not signed by patient

_____
Witness

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows us to place you under care.

1. **If You Do Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 at any time (unless on an authorized payment plan) or care may be terminated. If you have a large deductible remaining for the year, you may pay our cash price of $75 each visit until your deductible has been met. Please note you are still responsible for paying the entire amount due.

2. **If You Do Not Have Insurance:** All payments are expected at the time of service.

3. Patient understands patient is financially responsible for all charges and services rendered by provider. Any legal or collection expenses incurred by this clinic to collect balance owed by the patient will be the financial responsibility of the patient.

Our fees are considered to be usual, customary and reasonable by most insurance companies and therefore are covered up to the maximum allowance determined by each carrier. Because we are in network with many carriers and have contractual agreements with them, we are obligated to collect ALL co-pay and deductible amounts.

We agree to file insurance claim forms to your carrier on your behalf for all services rendered in our office. If your insurance denies a claim for any reason, it is your responsibility to pay the outstanding balance of the charges.

Patient's Printed Name:_____

Signature:_____ Date:_____

Office Manager:_____ Date:_____